

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following two Notices of Proposed Rulemaking were reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 730.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2011.

[R13-40]

PREAMBLE

- | <u>1. Article, Part, or Section Affected (as applicable)</u> | <u>Rulemaking Action</u> |
|--|--------------------------|
| R9-22-101 | Amend |
| R9-22-201 | Amend |
| R9-22-202 | Amend |
| R9-22-203 | Amend |
| R9-22-204 | Amend |
| R9-22-205 | Amend |
| R9-22-206 | Amend |
| R9-22-207 | Amend |
| R9-22-212 | Amend |
| R9-22-215 | Amend |
| R9-22-217 | Amend |
| R9-22-702 | Amend |
| R9-22-703 | Amend |
| R9-22-705 | Amend |
| R9-22-712.09 | Amend |
| R9-22-1205 | Amend |
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 36-2903.01
Implementing statute: A.R.S. § 36-2907, amended by § 13 of Laws 2011, Ch. 31 ("the 2011 Act")
- 3. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:**
Notice of Exempt Rulemaking: 16 A.A.R. 1638, August 27, 2010
Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1518, August 12, 2011
Notice of Public Information: 17 A.A.R. 1723, August 26, 2011
Notice of Exempt Rulemaking: 17 A.A.R. 1868, September 23, 2011
Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1522, August 12, 2011
Notice of Exempt Rulemaking: 17 A.A.R. 1870, September 23, 2011
Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1290, July 15, 2011
Notice of Exempt Rulemaking: 17 A.A.R. 1707, August 26, 2011
Notice of Proposed Exempt Rulemaking: 18 A.A.R. 1310, June 8, 2012
Notice of Exempt Rulemaking: 18 A.A.R. 1745, July 20, 2012
Notice of Rulemaking Docket Opening: 19 A.A.R. 728, April 12, 2013 (*in this issue*)
- 4. The agency's contact person who can answer questions about the rulemaking:**

Notices of Proposed Rulemaking

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov
Web site: www.azahcccs.gov

5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Governor's Medicaid Reform Plan, announced on March 15, 2011, proposals to reduce non federal expenditures for the AHCCCS program by approximately \$500 million during state fiscal year 2012. The AHCCCS Administration promulgated limitations to the following rules:

- R9-22-101, R9-22-201, R9-22-202, R9-22-203, R9-22-205, R9-22-206, R9-22-207, R9-22-212, and R9-22-215 – Delineation of service limitations/ exclusions as described in HB2010, Forty-ninth Legislature Seventh Special Session of 2010 and promulgated rule on August 27, 2010, with an effective date of October 1, 2010.
- R9-22-201, R9-22-204, R9-22-702, R9-22-703, R9-22-705, R9-22-712.09– Limitation of covered inpatient days for adults and changes to current rules regarding limitations on providers charging members for services promulgated on August 26, 2011 with an effective date of October 1, 2011.
- R9-22-204 – Limitation of Inpatient Days related to treatment of burns promulgated on July 20, 2012, with an effective date of October 1, 2012.
- R9-22-217 – Limitation of Inpatient days applies to the Federal Emergency Services program, therefore, the Administration is updated rule with cross-references to the Inpatient limit rule R9-22-204. Promulgated on September 23, 2011, with an effective date of October 1, 2011.
- R9-22-1205 – Limitation for respite services promulgated on September 23, 2011, with an effective date of October 1, 2011.

Due to legislation specified in Laws 2012, Ch. 299, § 7, the rulemaking authority authorized in Laws 2011, Ch. 31, § 34 (SB 1619) was repealed. Additionally, Laws 2012, Ch. 299, § 8 stipulated that rules adopted through the previous year's authority (SB 1619) would expire December 31, 2013, without specific statutory authority.

After an evaluation of the Agency's overall statutory authority regarding covered services, rates, and eligibility, AHCCCS has determined that it will re-promulgate certain rules implementing "program changes" made pursuant to Laws 2011, Ch. 31, § 34 by identifying the specific statutory authority for the rules to ensure that the rules continue beyond December 31, 2013, in accordance with Laws 2012, Ch. 299, § 8.

Therefore, to ensure continuity of the rules previously adopted under § 34, the AHCCCS Administration is re-promulgating the same rules which became effective October 1, 2011. No changes have been proposed to the language of the rules.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

Not applicable.

7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

8. The preliminary summary of the economic, small business, and consumer impact:

See previous issues listed under item 3 for summaries of economic impacts as applicable.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693

Notices of Proposed Rulemaking

Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov
Web site: www.azahcccs.gov

10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of March 18, 2013. Please send written or e-mail comments to the above address by the close of the comment period, 5:00 p.m., May 13, 2013.

Date: May 13, 2013
Time: 11:00 a.m.
Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 13, 2013
Time: 11:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
1010 N. Finance Center Dr, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: May 13, 2013
Time: 11:00 a.m.
Location: 2717 N. 4th St., STE 130
Flagstaff, AZ 86004
Nature: Public Hearing

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION**

ARTICLE 1. DEFINITIONS

Notices of Proposed Rulemaking

Section

R9-22-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section

R9-22-201. Scope of Services-related Definitions
 R9-22-202. General Requirements
 R9-22-203. ~~Repeated~~ Experimental Services
 R9-22-204. Inpatient General Hospital Services
 R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services
 R9-22-206. Organ and Tissue Transplant Services
 R9-22-207. Dental Services
 R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies
 R9-22-215. Other Medical Professional Services
 R9-22-217. Services Included in the Federal Emergency Services Program

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-702. Charges to Members
 R9-22-703. Payments by the Administration
 R9-22-705. Payments by Contractors
 R9-22-712.09. Hierarchy For Tier Assignment

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1205. Scope and Coverage of Behavioral Health Services

ARTICLE 1. DEFINITIONS

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition	Section or Citation
"Accommodation"	R9-22-701
"Act"	R9-22-101
"ADHS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Adverse action"	R9-22-101
"Affiliated corporate organization"	R9-22-101
"Aged"	42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
"Aggregate"	R9-22-701
"AHCCCS"	R9-22-101
"AHCCCS inpatient hospital day or days of care"	R9-22-701
"AHCCCS registered provider"	R9-22-101
"Ambulance"	A.R.S. § 36-2201
"Ancillary department"	R9-22-701
"Ancillary service"	R9-22-701
"Anticipatory guidance"	R9-22-201
"Annual enrollment choice"	R9-22-1701
"APC"	R9-22-701
"Appellant"	R9-22-101
"Applicant"	R9-22-101
"Application"	R9-22-101
"Assessment"	R9-22-1101
"Assignment"	R9-22-101
"Attending physician"	R9-22-101
"Authorized representative"	R9-22-101
"Authorization"	R9-22-201
"Auto-assignment algorithm"	R9-22-1701
"AZ-NBCCEDP"	R9-22-2001
"Baby Arizona"	R9-22-1401
"Behavior management services"	R9-22-1201
"Behavioral health adult therapeutic home"	R9-22-1201
"Behavioral health therapeutic home care services"	R9-22-1201
"Behavioral health evaluation"	R9-22-1201
"Behavioral health medical practitioner"	R9-22-1201

Notices of Proposed Rulemaking

"Behavioral health professional"	A.A.C. R9-20-1201
"Behavioral health recipient"	R9-22-201
"Behavioral health service"	R9-22-1201
"Behavioral health technician"	A.A.C. R9-20-1201
"BHS"	R9-22-1401
"Billed charges"	R9-22-701
"Blind"	R9-22-1501
"Burial plot"	R9-22-1401
"Business agent"	R9-22-701 and R9-22-704
"Calculated inpatient costs"	R9-22-712.07
"Capital costs"	R9-22-701
"Capped fee-for-service"	R9-22-101
"Caretaker relative"	R9-22-1401
"Case management"	R9-22-1201
"Case record"	R9-22-101
"Case review"	R9-22-101
"Cash assistance"	R9-22-1401
"Categorically eligible"	R9-22-101
"CCR"	R9-22-712
"Certified psychiatric nurse practitioner"	R9-22-1201
"Charge master"	R9-22-712
"Child"	R9-22-1503 and R9-22-1603
"Children's Rehabilitative Services" or "CRS"	R9-22-201
"Claim"	R9-22-1101
"Claims paid amount"	R9-22-712.07
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-201
"CMDP"	R9-22-1701
"CMS"	R9-22-101
"Continuous stay"	R9-22-101
"Contract"	R9-22-101
"Contract year"	R9-22-101
"Contractor"	A.R.S. § 36-2901
"Copayment"	R9-22-701, R9-22-711 and R9-22-1603
"Cost avoid"	R9-22-1201
"Cost-To-Charge Ratio"	R9-22-701
"Covered charges"	R9-22-701
"Covered services"	R9-22-101
"CPT"	R9-22-701
"Creditable coverage"	R9-22-2003 and 42 U.S.C. 300gg(c)
"Critical Access Hospital"	R9-22-701
"CRS"	R9-22-1401
"Cryotherapy"	R9-22-2001
"Customized DME"	R9-22-212
"Day"	R9-22-101 and R9-22-1101
"Date of the Notice of Adverse Action"	R9-22-1441
"DBHS"	R9-22-201
"DCSE"	R9-22-1401
"De novo hearing"	42 CFR 431.201
"Dentures" and "Denture services"	R9-22-201
"Department"	A.R.S. § 36-2901
"Dependent child"	A.R.S. § 46-101
"DES"	R9-22-101
"Diagnostic services"	R9-22-101
"Director"	R9-22-101
"Disabled"	R9-22-1501
"Discussion"	R9-22-101
"Disenrollment"	R9-22-1701
"DME"	R9-22-101
"DRI inflation factor"	R9-22-701
"E.P.S.D.T. services"	42 CFR 440.40(b)
"Eligibility posting"	R9-22-701
"Eligible person"	A.R.S. § 36-2901

Notices of Proposed Rulemaking

“Emergency behavioral health condition for the non-FES member”	R9-22-201
“Emergency behavioral health services for the non-FES member”	R9-22-201
“Emergency medical condition for the non-FES member”	R9-22-201
“Emergency medical services for the non-FES member”	R9-22-201
“Emergency medical or behavioral health condition for a FES member”	R9-22-217
“Emergency services costs”	A.R.S. § 36-2903.07
“Encounter”	R9-22-701
“Enrollment”	R9-22-1701
“Enumeration”	R9-22-101
“Equity”	R9-22-101
“Experimental services”	R9-22-101 R9-22-203
“Existing outpatient service”	R9-22-701
“Expansion funds”	R9-22-701
“FAA”	R9-22-1401
“Facility”	R9-22-101
“Factor”	R9-22-701 and 42 CFR 447.10
“FBR”	R9-22-101
“Federal financial participation” or “FFP”	42 CFR 400.203
“Federal poverty level” or “FPL”	A.R.S. § 36-2981
“Fee-For-Service” or “FFS”	R9-22-101
“FES member”	R9-22-101
“FESP”	R9-22-101
“First-party liability”	R9-22-1001
“File”	R9-22-1101
“Fiscal agent”	R9-22-210
“Fiscal intermediary”	R9-22-701
“Foster care maintenance payment”	42 U.S.C. 675(4)(A)
“FQHC”	R9-22-101
“Free Standing Children’s Hospital”	R9-22-701
“Fund”	R9-22-712.07
“Graduate medical education (GME) program”	R9-22-701
“Grievance”	A.A.C. R9-34-202
“GSA”	R9-22-101
“HCPCS”	R9-22-701
“Health care practitioner”	R9-22-1201
“Hearing aid”	R9-22-201
“HIPAA”	R9-22-701
“Home health services”	R9-22-201
“Homebound”	R9-22-1401
“Hospital”	R9-22-101
“ICU”	R9-22-701
“IHS”	R9-22-101
“IHS enrolled” or “enrolled with IHS”	R9-22-708
“IMD” or “Institution for Mental Diseases”	42 CFR 435.1010 and R9-22-201
“Income”	R9-22-1401 and R9-22-1603
“Indigent”	R9-22-1401
“Individual”	R9-22-211
“In-kind income”	R9-22-1420
“Inmate of a public institution”	42 CFR 435.1010
“Inpatient covered charges”	R9-22-712.07
“Insured entity”	R9-22-720
“Interested party”	R9-22-101
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR”	42 U.S.C. 1396d(d)
“Intern and Resident Information System”	R9-22-701
“LEEP”	R9-22-2001
“Legal representative”	R9-22-101
“Level I trauma center”	R9-22-2101

Notices of Proposed Rulemaking

"License" or "licensure"	R9-22-101
"Licensee"	R9-22-1201
"Liquid assets"	R9-22-1401
"Mailing date"	R9-22-101
"Medical education costs"	R9-22-701
"Medical expense deduction" or "MED"	R9-22-1401
"Medical record"	R9-22-101
"Medical review"	R9-22-701
"Medical services"	A.R.S. § 36-401
"Medical supplies"	R9-22-201
"Medical support"	R9-22-1401
"Medically necessary"	R9-22-101
"Medicare claim"	R9-22-101
"Medicare HMO"	R9-22-101
"Member"	A.R.S. § 36-2901
"Mental disorder"	A.R.S. § 36-501
"Milliman study"	R9-22-712.07
"Monthly equivalent"	R9-22-1421 and R9-22-1603
"Monthly income"	R9-22-1421 and R9-22-1603
"National Standard code sets"	R9-22-701
"New hospital"	R9-22-701
"NICU"	R9-22-701
"Noncontracted Hospital"	R9-22-718
"Noncontracting provider"	A.R.S. § 36-2901
"Non-FES member"	R9-22-201
"Non-IHS Acute Hospital"	R9-22-701
"Nonparent caretaker relative"	R9-22-1401
"Notice of Findings"	R9-22-109
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"OBHL"	R9-22-1201
"Observation day"	R9-22-701
"Occupational therapy"	R9-22-201
"Offeror"	R9-22-101
"Operating costs"	R9-22-701
"Organized health care delivery system"	R9-22-701
"Outlier"	R9-22-701
"Outpatient hospital service"	R9-22-701
"Ownership change"	R9-22-701
"Ownership interest"	42 CFR 455.101
"Parent"	R9-22-1603
"Partial Care"	R9-22-1201
"Participating institution"	R9-22-701
"Peer group"	R9-22-701
"Peer-reviewed study"	R9-22-2001
"Penalty"	R9-22-1101
"Pharmaceutical service"	R9-22-201
"Physical therapy"	R9-22-201
"Physician"	R9-22-101
"Physician assistant"	R9-22-1201
"Post-stabilization services"	R9-22-201 or 42 CFR 422.113
"PPC"	R9-22-701
"PPS bed"	R9-22-701
"Practitioner"	R9-22-101
"Pre-enrollment process"	R9-22-1401
"Premium"	R9-22-1603
"Prescription"	R9-22-101
"Primary care provider" or "PCP"	R9-22-101
"Primary care provider services"	R9-22-201
"Prior authorization"	R9-22-101
"Prior period coverage" or "PPC"	R9-22-701
"Procedure code"	R9-22-701
"Proposal"	R9-22-101
"Prospective rates"	R9-22-701
"Psychiatrist"	R9-22-1201

Notices of Proposed Rulemaking

"Psychologist"	R9-22-1201
"Psychosocial rehabilitation services"	R9-22-201
"Public hospital"	R9-22-701
"Qualified alien"	A.R.S. § 36-2903.03
"Qualified behavioral health service provider"	R9-22-1201
"Quality management"	R9-22-501
"Radiology"	R9-22-101
"RBHA" or "Regional Behavioral Health Authority"	R9-22-201
"Reason to know"	R9-22-1101
"Rebase"	R9-22-701
"Referral"	R9-22-101
"Rehabilitation services"	R9-22-101
"Reinsurance"	R9-22-701
"Remittance advice"	R9-22-701
"Resident"	R9-22-701
"Residual functional deficit"	R9-22-201
"Resources"	R9-22-1401
"Respiratory therapy"	R9-22-201
"Respite"	R9-22-1201
"Responsible offeror"	R9-22-101
"Responsive offeror"	R9-22-101
"Revenue Code"	R9-22-701
"Review"	R9-22-101
"Review month"	R9-22-101
"RFP"	R9-22-101
"Rural Contractor"	R9-22-718
"Rural Hospital"	R9-22-712.07 and R9-22-718
"Scope of services"	R9-22-201
"Section 1115 Waiver"	A.R.S. § 36-2901
"Service location"	R9-22-101
"Service site"	R9-22-101
"SOBRA"	R9-22-101
"Specialist"	R9-22-101
"Specialty facility"	R9-22-701
"Speech therapy"	R9-22-201
"Spendthrift restriction"	R9-22-1401
"Sponsor"	R9-22-1401
"Sponsor deemed income"	R9-22-1401
"Sponsoring institution"	R9-22-701
"Spouse"	R9-22-101
"SSA"	42 CFR 1000.10
"SSDI Temporary Medical Coverage"	R9-22-1603
"SSI"	42 CFR 435.4
"SSN"	R9-22-101
"Stabilize"	42 U.S.C. 1395dd
"Standard of care"	R9-22-101
"Sterilization"	R9-22-201
"Subcontract"	R9-22-101
"Submitted"	A.R.S. § 36-2904
"Substance abuse"	R9-22-201
"SVES"	R9-22-1401
"Therapeutic foster care services"	R9-22-1201
"Third-party"	R9-22-1001
"Third-party liability"	R9-22-1001
"Tier"	R9-22-701
"Tiered per diem"	R9-22-701
"Title IV-D"	R9-22-1401
"Title IV-E"	R9-22-1401
"Total Inpatient payments"	R9-22-712.07
"Trauma and Emergency Services Fund"	A.R.S. § 36-2903.07
"TRBHA" or "Tribal Regional Behavioral Health Authority"	R9-22-1201
"Treatment"	R9-22-2004
"Tribal Facility"	A.R.S. § 36-2981
"Unrecovered trauma center readiness costs"	R9-22-2101

"Urban Contractor"	R9-22-718
"Urban Hospital"	R9-22-718
"USCIS"	R9-22-1401
"Utilization management"	R9-22-501
"WWHP"	R9-22-2001

- B.** General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Act" means the Social Security Act.

"ADHS" means the Arizona Department of Health Services.

"Adverse action" means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

"Affiliated corporate organization" means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

"AHCCCS registered provider" means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

"Appellant" means an applicant or member who is appealing an adverse action by the Department or Administration.

"Applicant" means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

"Application" means an official request for AHCCCS medical coverage made under this Chapter.

"Assignment" means enrollment of a member with a contractor by the Administration.

"Attending physician" means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

"Authorized representative" means a person who is authorized to apply for medical assistance or act on behalf of another person.

"Capped fee-for-service" means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

"Case record" means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

"Case review" means the Administration's evaluation of an individual's or family's circumstances and case record in a review month.

"Categorically eligible" means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

"CMS" means the Centers for Medicare and Medicaid Services.

"Continuous stay" means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

"Contract" means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

"Contract year" means the period beginning on October 1 of a year and continuing until September 30 of the following year.

"Covered services" means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

"Day" means a calendar day unless otherwise specified.

"DES" means the Department of Economic Security.

"Diagnostic services" means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

"Director" means the Director of the Administration or the Director's designee.

"Discussion" means an oral or written exchange of information or any form of negotiation.

"DME" means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

"Enumeration" means the assignment of a nine-digit identification number to a person by the Social Security Administration.

"Equity" means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

~~"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not~~

~~generally and widely accepted as a standard of care in the practice of medicine in the United States unless:~~

~~The weight of the evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or~~

~~In the absence of peer-reviewed articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.~~

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

“FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

“Fee-For-Service” or “FFS” means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

“FES member” means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

“FESP” means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

“Hospital” means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“IHS” means Indian Health Service.

“Interested party” means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

“License” or “licensure” means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

“Mailing date” when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

“Medical record” means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

“Medically necessary” means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

“Medicare claim” means a claim for Medicare-covered services for a member with Medicare coverage.

“Medicare HMO” means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417(L).

“Offeror” means an individual or entity that submits a proposal to the Administration in response to an RFP.

“Physician” means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Practitioner” means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

“Prescription” means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member's health care.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services contingent on the medical necessity of the services.

“Prior period coverage” means the period prior to the member's enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

“Proposal” means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

“Radiology” means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

“Referral” means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

“Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level.

“Responsible offeror” means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

“Responsive offeror” means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

“Review” means a review of all factors affecting a member's eligibility.

“Review month” means the month in which the individual's or family's circumstances and case record are reviewed.

“RFP” means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

“Service location” means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

“Service site” means a location designated by a contractor as the location at which a member is to receive covered services.

“S.O.B.R.A.” means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

“Specialist” means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

“Spouse” means a person who has entered into a contract of marriage recognized as valid by this state.

“SSN” means Social Security number.

“Standard of care” means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

“Subcontract” means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. Scope of Services-related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Anticipatory guidance” means a person responsible for a child receives information and guidance of what the person should expect of the child's development and how to help the child stay healthy.

“Behavioral health recipient” means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

“Benefit year” means a one year time period of October 1st through September 30th.

“Clinical supervision” means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

“Emergency behavioral health condition for a non-FES member” means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

“Emergency behavioral health services for a non-FES member” means those behavioral health services provided for the treatment of an emergency behavioral health condition.

“Emergency medical condition for a non-FES member” means treatment for a medical condition, including labor and

Notices of Proposed Rulemaking

delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the member's health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

"Emergency medical services for non-FES member" means services provided for the treatment of an emergency medical condition.

"Hearing aid" means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

"Home health services" means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

"Occupational therapy" means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual's ability to perform tasks required for independent functioning.

"Pharmaceutical service" means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

"Physical therapy" means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

"Post-stabilization services" means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

"Primary care provider services" means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

"Psychosocial rehabilitation services" means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

- Living skills training,
- Cognitive rehabilitation,
- Health promotion,
- Supported employment, and
- Other services that increase social and communication skills to maximize a member's ability to participate in the community and function independently.

"RBHA" or "Regional Behavioral Health Authority" means the same as in A.R.S. § 36-3401.

"Residual functional deficit" means a member's inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

"Respiratory therapy" means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Speech therapy" means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

"Sterilization" means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

- Prevent the progression of disease, disability, or adverse health conditions; or
- Prolong life and promote physical health.

"Substance abuse" means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-202. General Requirements

A. No Change

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:

1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
3. The Administration or a contractor may waive the covered services referral requirements of this Article.
4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner,

Notices of Proposed Rulemaking

or a dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.

5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
6. A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider or upon authorization by the contractor or the contractor's designee.
7. ~~A member may receive treatment that is considered the standard of care or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.~~

~~8-7.~~ AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.

~~9-8.~~ An AHCCCS registered provider shall provide covered services within the provider's scope of practice.

~~10-9.~~ In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:

- a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
- b. Services or items furnished gratuitously, and
- c. Personal care items except as specified under R9-22-212.

~~11-10.~~ Medical or behavioral health services are not covered services if provided to:

- a. An inmate of a public institution;
- b. A person who is in residence at an institution for the treatment of tuberculosis; or
- c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.

C. No Change

D. No Change

E. No Change

F. No Change

G. No Change

H. No Change

I. No Change

J. No Change

K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for one hundred percent federal financial participation:

1. R9-22-205(A)(8)
2. R9-22-205(B)(4)(f)
3. R9-22-206
4. R9-22-207
5. R9-22-212(C)
6. R9-22-212(D)
7. R9-22-212(E)(8)
8. R9-22-215(C)(2)
9. R9-22-215(C)(5)

R9-22-203. ~~Repealed~~ Experimental Services

A. Experimental services are not covered. A service is not experimental if:

1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.
2. The service does not meet the standard in (1), but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.
3. The service does not meet the standard in (2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.

B. The following factors shall be considered when evaluating the weight of peer-reviewed articles or the opinions of specialists:

1. The mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services;
2. The types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services;
3. The frequency with which the service has been performed in the past.

Notices of Proposed Rulemaking

4. Whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits.
5. The reputation and experience of the authors and/or specialists and their record in related areas.
6. The extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future.
7. Whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study.

R9-22-204. Inpatient General Hospital Services

A. No Change

B. No Change

C. Coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year for members age 21 and older. The limit applies for all inpatient hospital services with dates of service during the benefit year regardless of whether the member is enrolled in Fee for Service, is enrolled with one or more contractors, or both, during the benefit year.

1. For purposes of calculating the limit:

- a. Inpatient days are counted towards the limit if paid by the Administration or a contractor;
- b. Inpatient days will be counted toward the limit in the order of the adjudication date of a paid claim;
- c. Paid inpatient days are allocated to the benefit year in which the date of service occurs;
- d. Each 24 hours of paid observation services is counted as one inpatient day if the patient is not admitted to the same hospital directly following the observation services.
- e. Observation services, which are directly followed by an inpatient admission to the same hospital are not counted towards the inpatient limit; and
- f. After 25 days of inpatient hospital services have been paid as provided for in this section:
 - i. Outpatient services that are directly followed by an inpatient admission to the same hospital, including observation services, are not covered.
 - ii. Continuous periods of observation services of less than 24 hours that are not directly followed by an inpatient admission to the same hospital are covered.
 - iii. For continuous periods of observation services of 24 hours or more that are not directly followed by an inpatient admission to the same hospital, 23 hours of observations services are covered.

2. The following inpatient days are not included in the inpatient hospital limitation described in this section:

- a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract;
- b. Days related to Behavioral Health:
 - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
- c. Days related to treatment for burns and burn late effects at an American College of Surgeons verified burn center;
- d. Same Day Admit Discharge services are excluded from the 25 day limit; and
- e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

R9-22-205. Attending Physician, Practitioner, and Primary Care Provider Services

A. A primary care provider, attending physician, or practitioner shall provide primary care provider services within the provider's scope of practice under A.R.S. Title 32. A member may receive primary care provider services in an inpatient or outpatient setting including at a minimum:

1. Periodic health examination and assessment;
2. Evaluation and diagnostic workup;
3. Medically necessary treatment;
4. Prescriptions for medication and medically necessary supplies and equipment;
5. Referral to a specialist or other health care professional if medically necessary;
6. Patient education;
7. Home visits if medically necessary; and

~~8. Covered immunizations; and~~

~~9-8. Covered preventive~~ Except as provided in subsection (B), preventive health services, such as, immunizations, colonoscopies, mammograms and PAP smears.

Notices of Proposed Rulemaking

- B.** The following limitations and exclusions apply to attending physician and practitioner services and primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider, or to a member upon referral from the attending physician or practitioner are limited to the service or condition for which the referral is made, or for which authorization is given by the Administration or a contractor.
 2. A member's physical examination is not covered if the sole purpose is to obtain documentation for one or more of the following:
 - a. Qualification for insurance;
 - b. Pre-employment physical evaluation;
 - c. Qualification for sports or physical exercise activities;
 - d. Pilot's examination for the Federal Aviation Administration;
 - e. Disability certification to establish any kind of periodic payments;
 - f. Evaluation to establish third-party liabilities; or
 - g. Physical ability to perform functions that have no relationship to primary objectives of the services listed in subsection (A).
 3. Orthognathic surgery is covered only for a member who is less than 21 years of age;
 4. The following services are excluded from AHCCCS coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and gender reassignment surgeries;
 - b. Pregnancy termination counseling services;
 - c. ~~For federally funded programs, pregnancy~~ Pregnancy terminations, unless required by state or federal law.
 - d. Services or items furnished solely for cosmetic purposes; ~~and~~
 - e. Hysterectomies unless determined medically necessary; ~~and~~
 - f. Preventive services not covered are well exams, meaning physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination.

R9-22-206. Organ and Tissue Transplant Services

- A.** No Change
- B.** ~~Pancreas transplants are not covered for individuals 21 years of age or older if it is not performed simultaneously with a kidney transplant (pancreas only transplants). Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with a kidney transplant.~~
- B.** The following transplants are not covered for members 21 years of age or older:
1. Heart transplants for non-ischemic cardiomyopathy;
 2. Liver transplants for members with a diagnosis of Hepatitis C;
 3. Pancreas only transplants if it is not performed simultaneously with a kidney transplant. Partial pancreas transplants and autologous and allogeneic pancreas islet cell transplants are not covered even if performed simultaneously with a kidney transplant;
 4. Pancreas transplants after a kidney transplant;
 5. Lung transplants;
 6. Allogeneic unrelated Hematopoietic Cell transplants;
 7. Intestine transplants; and
 8. Any other type of transplant not specifically listed in subsection (A).
- C.** ~~Organ and tissue transplant services are not covered for qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).~~
- C.** When there is a transplant of multiple organs, reimbursement will only be made for those covered.
- D.** Organ and tissue transplant services are not covered for qualified aliens or noncitizens members of FESP under A.R.S. § 36-2903.03(D).

R9-22-207. Dental Services

- A.** No Change
- B.** ~~The Administration or a contractor shall cover the following emergency dental care services:~~
1. ~~Oral diagnostic examination including laboratory and radiographs if necessary to determine an emergency medical condition;~~
 2. ~~Immediate and palliative procedures, including extractions if medically necessary, for relief of severe pain associated with an oral or maxillofacial condition;~~
 3. ~~Initial treatment for acute infection;~~
 4. ~~Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;~~
 5. ~~Preoperative procedures; and~~
 6. ~~Anesthesia appropriate for optimal patient management.~~

Notices of Proposed Rulemaking

- B.** For individuals age 21 years of age or older, the Administration or a contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician.
1. Except as specified in (C), such services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examination of the oral cavity, radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.
 2. Such services do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
- ~~C.~~ ~~Covered denture services are medically necessary dental services and procedures associated with, and including, the provision of dentures.~~
- C.** For the purposes of this subsection, simple restorations means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns. In addition, dental services for an individual 21 years of age or older include:
1. The elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to covered transplantation; and
 2. Prophylactic extraction of teeth in preparation for covered radiation treatment of cancer of the jaw, neck or head.
- ~~D.~~ ~~The following limitations apply to dentures:~~
1. ~~Provision of dentures for cosmetic purposes is not a covered service;~~
 2. ~~Extractions of asymptomatic teeth are not covered unless their removal is the most cost-effective dental procedure for the provision of dentures; and~~
 3. ~~Radiographs are covered only if used as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures.~~
- ~~E.~~ ~~The following limitations apply to emergency dental services provided by the Administration's fee-for-service providers for a member age 21 or older:~~
1. ~~Treatment for the prevention of pulpal death and imminent tooth loss is covered only for non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are covered only to treat active infection or to eliminate pain;~~
 2. ~~Routine restorative procedures and routine root canal therapy are not emergency services and are not covered;~~
 3. ~~Radiographs are covered only for symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;~~
 4. ~~Maxillofacial dental services provided by a dentist are not covered unless prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and~~
 5. ~~Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.~~
- F.** Prior authorization of dental services for a FFS member is required from the Administration for the following:
1. Provision of medically necessary dentures;
 2. Replacement, repair, or adjustment to dentures; and
 3. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.

R9-22-212. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies

- A.** Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs as specified in subsection (E), are covered services to the extent permitted in this Section if provided in compliance with requirements of this Chapter, and:
1. Prescribed by the primary care provider, attending physician, or practitioner, ~~or dentist~~; or
 2. Prescribed by a specialist upon referral from the primary care provider, attending physician, or practitioner, ~~or dentist~~; and
 3. Authorized as required by the Administration, contractor, or contractor's designee.
- B.** No Change
- C.** Covered DME is any item, appliance, or piece of equipment that is not a prosthetic or orthotic and:
1. ~~Designed~~ Is designed for a medical purpose, and is generally not useful to a person in the absence of an illness or injury, and
 2. ~~Designed to withstand wear~~ Can withstand repeated use, and
 3. ~~Generally~~ Is generally reusable by others; ~~and,~~
 4. ~~Purchased or rented for a member.~~
- ~~D.~~ ~~Covered prosthetic and orthotic devices are only those items that are essential for the habilitation or rehabilitation of a member.~~
- Prosthetics are devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or

Notices of Proposed Rulemaking

malfunctioning portion of the body. Only those prosthetics that are medically necessary for rehabilitation are covered, except as otherwise provided in R9-22-215.

E. The following limitations on coverage apply:

1. The DME is furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the DME does not exceed the cost of the DME if purchased.
2. Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair or adjustment is less than the cost of renting or purchasing another unit.
3. A change in, or addition to, an original order for DME is covered if approved by the prescriber in subsection (A), or prior authorized by the Administration or contractor, and the change or addition is indicated clearly on the order and initialed by the vendor. No change or addition to the original order for DME may be made after a claim for services is submitted to the member's contractor, or the Administration, without prior written notification of the change or addition to the Administration or the contractor.
4. Reimbursement for rental fees shall terminate:
 - a. No later than the end of the month in which the prescriber in subsection (A) certifies that the member no longer needs the DME;
 - b. If the member is no longer eligible for AHCCCS services; or
 - c. If the member is no longer enrolled with a contractor, with the exception of transitions of care as specified in R9-22-509.
5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.
6. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:
 - a. The member is over 3 years old and under 21 years old;
 - b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;
 - c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;
 - d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;
 - e. The member obtains incontinence briefs from providers in the contractor's network;
 - f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that:
 - i. The member is over age 3 and under age 21;
 - ii. The member has a disability that causes incontinence of bladder or bowel, or both;
 - iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and
 - iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. First aid supplies are not covered unless they are provided in accordance with a prescription.
8. ~~Hearing aids are not covered for a member who is age 21 or older.~~
9. ~~Prescriptive lenses are not covered for a member who is age 21 or older unless they are the sole visual prosthetic device used by the member after a cataract extraction.~~
8. The following services are not covered for individuals 21 years of age or older:
 - a. Hearing aids;
 - b. Prescriptive lenses, unless they are the sole visual prosthetic device used by the member after a cataract extraction;
 - c. Bone Anchor Hearing Aid (BAHA);
 - d. Cochlear implant;
 - e. Percussive vest;
 - f. Insulin pump;
 - g. Microprocessor-controlled lower limbs or microprocessor-controlled joints for lower limbs; and
 - h. Orthotics, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body.

F. No Change

Notices of Proposed Rulemaking

R9-22-215. Other Medical Professional Services

- A.** The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting as follows:
1. Dialysis;
 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications;
 - b. Supplies;
 - c. Devices; and
 - d. Surgical procedures.
 3. Family planning services are limited to:
 - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
 4. Midwifery services provided by a certified nurse practitioner in midwifery;
 5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
 6. ~~Podiatry services when ordered by a member's primary care provider, attending physician, or practitioner;~~
 - 7-6. Respiratory therapy;
 - 8-7. Ambulatory and outpatient surgery facilities services;
 - 9-8. Home health services under A.R.S. § 36-2907(D);
 - 10-9. Private or special duty nursing services when medically necessary and prior authorized;
 - 11-10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
 - 12-11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
 - 13-12. Inpatient chemotherapy; and
 - 14-13. Outpatient chemotherapy.
- B.** Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through ~~(12)~~ (11).
- C.** The following services are excluded as covered services:
1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
 2. Physical therapy provided only as a maintenance regimen;
 3. Abortion counseling; ~~or~~
 4. Services or items furnished solely for cosmetic purposes;
 5. Services provided by a podiatrist; or
 6. More than 15 outpatient physical therapy visits per contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.

R9-22-217. Services Included in the Federal Emergency Services Program

- A.** No Change
- B.** No Change
- C.** No Change
- D.** No Change
- E.** Services rendered through the Federal Emergency Services Program are subject to all exclusions and limitation on services in this Article including but not limited to the limitations on inpatient hospital services in R9-22-204.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-702. Charges to Members

- A.** ~~Except as provided in subsections (B), (C), and (D), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was not an eligible person on the date of service:~~
1. ~~Charge, submit a claim to, or demand or collect payment from a person claiming to be an eligible person; or~~
 2. ~~Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency.~~
- B.** ~~An AHCCCS registered provider that submits a claim shall not charge more than the actual, reasonable cost of providing the covered service.~~
- C.** ~~An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member as follows:~~
1. ~~To collect an authorized copayment;~~
 2. ~~To recover from a member that portion of a payment made by a third party to the member if the payment duplicates~~

Notices of Proposed Rulemaking

- AHCCCS paid benefits and is not assigned to a contractor; or
3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied.
- D.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment for services from a member if:
1. The member requests the provision of a service that is not covered or not authorized by the contractor or the Administration; and
 2. The provider prepares and provides the member with a document describing the overall services and the approximate cost of the services; and
 3. The member signs the document prior to services being provided, indicating that the member understands and accepts responsibility for payment.
- E.** Notwithstanding subsection (D), an AHCCCS registered provider may charge, submit a claim to, or demand or collect payment for services from a member eligible for the FESP if:
1. The provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition; and
 2. The Administration denies the claim because the service does not meet the criteria of R9-22-217.
- A.** For purposes of this subsection, the term "member" includes the member's financially responsible representative as described under A.R.S. § 36-2903.01.
- B.** Registered providers must accept payment from the Administration or a contractor as payment in full.
- C.** Except as provided in subsection (D) a registered provider shall not request or collect payment from, refer to a collection agency, or report to a credit reporting agency an eligible person or a person claiming to be an eligible person.
- D.** An AHCCCS registered provider may charge, submit a claim to, or demand or collect payment from a member:
1. To collect the copayment described in R9-22-711;
 2. To recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or the contractor as required by the statutory assignment of rights to AHCCCS;
 3. To obtain payment from a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused payment to the provider to be reduced or denied;
 4. For a service that is excluded by statute or rule, or provided in an amount that exceeds a limitation in statute or rule, if the member signs a document in advance of receiving the service stating that the member understands the service is excluded or is subject to a limit and that the member will be financially responsible for payment for the excluded service or for the services in excess of the limit;
 5. When the contractor or the Administration has denied authorization for a service if the member signs a document in advance of receiving the service stating that the member understands that authorization has been denied and that the member will be financially responsible for payment for the service;
 6. For services requested for a member enrolled with a contractor, and rendered by a noncontracting provider under circumstances where the member's contractor is not responsible for payment of "out of network" services under R9-22-705(A), if the member signs a document in advance of receiving the service stating that the member understands the provider is out of network, that the member's contractor is not responsible for payment, and that the member will be financially responsible for payment for the excluded service;
 7. For services rendered to a person eligible for the FESP if the provider submits a claim to the Administration in the reasonable belief that the service is for treatment of an emergency medical condition and the Administration denies the claim because the service does not meet the criteria of R9-22-217; or
 8. If the provider has received verification from the Administration that the person was not an eligible person on the date of service.
- E.** The signature requirement of subsections (D)(4), (D)(5), and (D)(6) do not apply if:
1. The member is unable or incompetent to sign such a document, or
 2. When services are rendered for the purpose of treating an emergency medical condition as defined in R9-22-217 and a delay in providing treatment to obtain a signature would have a significant adverse affect on the member's health.
- F.** Except as provided for in this section, registered providers shall not bill a member when the provider could have received reimbursement from the Administration or a contractor but for the provider's failure to file a claim in accordance with the requirements of AHCCCS statutes, rules, the provider agreement, or contract, such as, but not limited to, requirements to request and obtain prior authorization, timely filing, and clean claim requirements.

R9-22-703. Payments by the Administration

- A. No Change
- B. No Change

Notices of Proposed Rulemaking

- C. No Change
- D. No Change
- E. No Change
- F. No Change

G. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

R9-22-705. Payments by Contractors

- A. No Change
- B. No Change
- C. No Change
- D. No Change
- E. No Change
- F. No Change
- G. No Change
- H. No Change
- I. No Change

J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:

1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a ± one percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

K. No Change

L. For services subject to limitations or exclusions such as the number of hours, days, or visits covered as described in Article 2 of this Chapter, once the limit is reached the Administration will not reimburse the services.

R9-22-712.09. Hierarchy For Tier Assignment

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx - 643.xx, 644.2x - 676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code of 174 and the provider has a Level II or Level III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND <u>primary</u> Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx - 316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17x, not equal to 174.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

ARTICLE 12. BEHAVIORAL HEALTH SERVICES

R9-22-1205. Scope and Coverage of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services are covered subject to the limitations and exclusions in this Article.

1. Covered inpatient behavioral health services include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment, if the service is provided under the direction of a physician in a Medicare-certified:
 - a. General acute care hospital, or
 - b. Inpatient psychiatric hospital.
2. Inpatient service limitations:

- a. Inpatient services, other than emergency services specified in this Section, are not covered unless prior authorized.
- b. Inpatient services and room and board are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - i. A licensed psychiatrist,
 - ii. A certified psychiatric nurse practitioner,
 - iii. A licensed physician assistant,
 - iv. A licensed psychologist,
 - v. A licensed clinical social worker,
 - vi. A licensed marriage and family therapist,
 - vii. A licensed professional counselor,
 - viii. A licensed independent substance abuse counselor, and
 - ix. A behavioral health medical practitioner.
- c. A member age 21 through 64 is eligible for behavioral health services provided in a hospital listed in subsection (A)(1)(b) that meets the criteria for an IMD up to 30 days per admission and no more than 60 days per ~~contract~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS.

B. No Change

C. Covered Level 1 sub-acute agency services. Services provided in a Level 1 sub-acute agency as defined in A.A.C. R9-20-101 are covered subject to the limitations and exclusions under this Article.

1. Level 1 sub-acute agency services are not covered unless provided under the direction of a licensed physician in a licensed Level 1 sub-acute agency that is accredited by an AHCCCS-approved accrediting body as specified in contract.
2. Covered level 1 sub-acute agency services include room and board and treatment services for behavioral health and substance abuse conditions.
3. Services are reimbursed on a per diem basis. The per diem rate includes all services, except the following licensed or certified providers may bill independently for services:
 - a. A licensed psychiatrist,
 - b. A certified psychiatric nurse practitioner,
 - c. A licensed physician assistant,
 - d. A licensed psychologist,
 - e. A licensed clinical social worker,
 - f. A licensed marriage and family therapist,
 - g. A licensed professional counselor,
 - h. A licensed independent substance abuse counselor, and
 - i. A behavioral health medical practitioner.
4. The following may be billed independently if prescribed by a provider specified in this Section who is operating within the scope of practice:
 - a. Laboratory services,
 - b. Radiology services, and
 - c. Psychotropic medication.
5. A member age 21 through 64 is eligible for behavioral health services provided in a level 1 sub-acute agency that meets the criteria for an IMD for up to 30 days per admission and no more than 60 days per ~~contract~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 or age 65 or over.

D. No Change

E. No Change

F. No Change

G. No Change

H. No Change

I. Other covered behavioral health services. Other covered behavioral health services include:

1. Case management as defined in R9-22-1201;
2. Laboratory and radiology services for behavioral health diagnosis and medication management;
3. Psychotropic medication and related medication;
4. Monitoring, administration, and adjustment for psychotropic medication and related medications;
5. Respite care as described within subsection (K);
6. Behavioral health therapeutic home care services provided by a RBHA in a professional foster home defined in 6 A.A.C. 5, Article 58 or in a behavioral health adult therapeutic home as defined in 9 A.A.C. 20, Article 1;
7. Personal care services, including assistance with daily living skills and tasks, homemaking, bathing, dressing, food preparation, oral hygiene, self-administration of medications, and monitoring of the behavioral health recipient's con-

Notices of Proposed Rulemaking

dition and functioning level provided by a licensed and AHCCCS-registered behavioral health agency or a behavioral health professional, behavioral health technician, or behavioral health paraprofessional as defined in 9 A.A.C. 20, Article 1; and

8. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services. Transportation services are covered under R9-22-211.

K. Limited Behavioral Health services. Respite services are limited to no more than 600 hours per benefit year.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM**

[R13-38]

PREAMBLE

- | <u>1. Article, Part, or Section Affected (as applicable)</u> | <u>Rulemaking Action</u> |
|---|---------------------------------|
| R9-28-204 | Amend |
| R9-28-205 | Amend |
- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2907, amended by § 13 of Laws 2011, Ch. 31 (“the 2011 Act”)
- 3. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:**

Notice of Proposed Exempt Rulemaking: 17 A.A.R. 1526, August 12, 2011

Notice of Exempt Rulemaking: 17 A.A.R. 1876, September 23, 2011

Notice of Rulemaking Docket Opening: 19 A.A.R. 729, April 12, 2013 (*in this issue*)
- 4. The agency’s contact person who can answer questions about the rulemaking:**

Name: Mariaelena Ugarte

Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

Web site: www.azahcccs.gov
- 5. An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:**

The Governor's Medicaid Reform Plan, announced on March 15, 2011, proposals to reduce non-federal expenditures for the AHCCCS program by approximately \$500 million during state fiscal year 2012. The AHCCCS Administration promulgated limitations to respite services on September 23, 2011, with an effective date of October 1, 2011.

Due to legislation specified in Laws 2012, Ch. 299, § 7, the rulemaking authority authorized in Laws 2011, Ch. 31, § 34 (SB 1619) was repealed. Additionally, Laws 2012, Ch. 299, § 8 stipulated that rules adopted through the previous year’s authority (SB1619) would expire December 31, 2013, without specific statutory authority.

After an evaluation of the Agency’s overall statutory authority regarding covered services, rates, and eligibility, AHCCCS has determined that it will re-promulgate certain rules implementing “program changes” made pursuant to Laws 2011, Ch. 31, § 34 by identifying the specific statutory authority for the rules to ensure that the rules continue beyond December 31, 2013, in accordance with Laws 2012, Ch. 299, § 8.

Therefore, to ensure continuity of the rules previously adopted under § 34, the AHCCCS Administration is re-promulgating the same rules which became effective October 1, 2011. No changes have been proposed to the language of the rules.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were relied upon for the implementation of this rulemaking, but analysis of the member utilization of respite services reported through claims and encounters for dates of service during SFY 2010, has assisted the AHCCCS Administration in arriving at the limitations. Prior to promulgation, AHCCCS reviewed historical information regarding utilization of the services limited by the rule. Based on that review, AHCCCS determined that at least 75 percent of utilizing members would remain unaffected if these limitations are implemented.

7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

8. The preliminary summary of the economic, small business, and consumer impact:

AHCCCS estimates that the limitations on respite hours will reduce total expenditures by approximately \$5.2 million in combined state and federal funds for the state fiscal year 2012.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov
Web site: www.azahcccs.gov

10. The time, place, and nature of the proceedings to make, amend, repeal, or renumber the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of March 18, 2013. Please send written or e-mail comments to the above address by the close of the comment period, 5:00 p.m., May 13, 2013.

Date: May 13, 2013
Time: 11:00 a.m.
Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 13, 2013
Time: 11:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
1010 N. Finance Center Dr, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: May 13, 2013
Time: 11:00 a.m.
Location: 2717 N. 4th St. STE 130
Flagstaff, AZ 86004
Nature: Public Hearing

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or

Notices of Proposed Rulemaking

class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ARIZONA LONG-TERM CARE SYSTEM**

ARTICLE 2. COVERED SERVICES

Section

R9-28-204. Institutional Services

R9-28-205. Home and Community Based Services (HCBS)

ARTICLE 2. COVERED SERVICES

R9-28-204. Institutional Services

A. No Change

B. The Administration and a contractor shall include the following services in the per diem rate for a facility listed in subsection (A):

1. Nursing care services;
2. Rehabilitative services prescribed as a maintenance regimen;
3. Restorative services, such as range of motion;
4. Social services;
5. Nutritional and dietary services;
6. Recreational therapies and activities;
7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
8. Overall management and evaluation of a member's care plan;
9. Observation and assessment of a member's changing condition;
10. Room and board services, including supporting services such as food and food preparation, personal laundry, and housekeeping;
11. Non-prescription and stock pharmaceuticals; and
- ~~12. Respite care services not to exceed 30 days per contract year.~~
- ~~12. Respite care services not to exceed 600 hours per benefit year.~~

C. No Change

D. Limitations. The following limitations apply:

1. A private room in a NF, ICF-MR, or facility identified in R9-28-1105(A)(1)(b), (B), or (C) is covered only if:
 - a. The member or has a medical condition that requires isolation, and
 - b. The member's primary care provider or attending physician provides written authorization;
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
3. Bed hold days as authorized by the Administration or its designee for a fee-for-service provider shall meet the following criteria:

Notices of Proposed Rulemaking

- a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS ~~contract year~~ benefit year, and is available if a member is admitted to a hospital for a short stay. After the short-term hospitalization, the member is returned to the institutional facility from which leave is taken, and to the same bed if the level of care required can be provided in that bed; and
- b. Therapeutic leave for a member age 21 and older is limited to nine days per AHCCCS ~~contract year~~ benefit year. A physician order is required for therapeutic leave from the facility for one or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the member is returned to the same bed within the institutional facility;
- c. Therapeutic leave and short-term hospitalization leave are limited to any combination of 21 days per ~~contract year~~ benefit year for a member under age 21;
4. The Administration or a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's case manager or the case manager's designee if:
 - a. The services are ordered by the member's primary care provider; and
 - b. The services are specified in a case management plan under R9-28-510;
5. A member age 21 through 64 is eligible for behavioral health services provided in a facility under subsection (A)(3) that has more than 16 beds, for up to 30 days per admission and no more than 60 days per ~~contract year~~ benefit year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified by 42 CFR 441.151, May 22, 2001, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
6. The limitations in subsection (D)(5) do not apply to a member:
 - a. Under age 21 or age 65 or over, or
 - b. In a facility with 16 beds or less.

R9-28-205. Home and Community Based Services (HCBS)

A. No Change

B. No Change

C. Home and community based services include the following:

1. Home health services provided on a part-time or intermittent basis. These services include:
 - a. Nursing care;
 - b. Home health aide;
 - c. Medical supplies, equipment, and appliances;
 - d. Physical therapy;
 - e. Occupational therapy;
 - f. Respiratory therapy; and
 - g. Speech and audiology services;
2. Private duty nursing services;
3. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
4. Transportation services to obtain covered medically necessary services;
5. Adult day health services provided to a member in an adult day health care facility licensed under 9 A.A.C. 10, Article 5, including:
 - a. Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Personal living skills training;
 - d. Meals and health monitoring;
 - e. Preventive, therapeutic, and restorative health related services; and
 - f. Behavioral health services, provided either directly or through referral, if medically necessary;
6. Personal care services;
7. Homemaker services;
8. Home delivered meals, that provide at least one-third of the recommended dietary allowance, for a member who does not have a developmental disability under A.R.S. § 36-551;
- ~~9. Respite care services for no more than 720 hours per contract year;~~
9. Respite care services for no more than 600 hours per benefit year;
10. Habilitation services including:
 - a. Physical therapy;
 - b. Occupational therapy;
 - c. Speech and audiology services;
 - d. Training in independent living;
 - e. Special development skills that are unique to the member;

Notices of Proposed Rulemaking

- f. Sensory-motor development;
- g. Behavior intervention; and
- h. Orientation and mobility training;
- 11. Developmentally disabled day care provided in a group setting during a portion of a 24-hour period, including:
 - a. Supervision of activities specified in the member's care plan;
 - b. Personal care;
 - c. Activities of daily living skills training; and
 - d. Habilitation services; and
- 12. Supported employment services provided to a member in the ALTCS transitional program under R9-28-306 who is developmentally disabled under A.R.S. § 36-551.